Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HALIFAX REGIONAL HOSPITAL
2204 WILBORN AVE
SOUTH BOSTON VA 24592-1645

Respondent Name
INSURANCE COMPANY OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-2524-01

MFDR Date Received
December 22, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "UCR does not apply in Virginia for hospitals. We do not have a contract with insurance company. Employee hurt while working. Insurance should pay at least 80% of Billed Charges."

Amount in Dispute: $7,124.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that the Carrier did reimburse the proper amount per the Texas WC Fee Guidelines. . . . Our system shows a Focus-Aetna WC Access LLC contract. I am verifying that this contract was still in place for this date of service."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2009	Outpatient Hospital Services	$7,124.54	$3,785.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 sets out requirements regarding written notification to health care providers of contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (45) Charges exceed your contracted/legislated fee arrangement.
   - 2 – (W1) Workers Compensation State Fee Schedule Adjustment
   - 3 – (97) Payment is included in the allowance for another service/procedure.
   - 4 – (96) Non-covered charge(s).
   - 3 – (18) Duplicate claim/service.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided outpatient hospital services in the state of Virginia on August 11, 2009 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." The respondent's position statement asserts that "Our system shows a Focus-Aetna WC Access LLC contract. I am verifying that this contract was still in place for this date of service." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the date of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed date of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490, date of service August 11, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code A4618 has a status indicator of Y, which denotes non-Implantable durable medical equipment not paid under OPPS. Reimbursement is not recommended.
- Procedure code E0485 has a status indicator of Y, which denotes non-Implantable durable medical equipment not paid under OPPS. Reimbursement is not recommended.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.36. 125% of this amount is $15.45. The recommended payment is $15.45.
- Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.45. 125% of this amount is $11.81. The recommended payment is $11.81.
- Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $34.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $20.73. This amount multiplied by the annual wage index for this facility of 0.9659 yields an adjusted labor-related amount of $20.02. The non-labor related portion is 40% of the APC rate or $13.82. The sum of the labor and non-labor related amounts is $33.84. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $33.84. This amount multiplied by 200% yields a MAR of $67.68.
- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.9659 yields an adjusted labor-related amount of $25.91. The non-labor related portion is 40% of the APC rate or $17.88. The sum of the labor and non-labor related amounts is $43.79. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $43.79. This amount multiplied by 200% yields a MAR of $87.58.
- Procedure code 24201 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0021, which, per OPPS Addendum A, has a payment rate of $1,050.17. This amount multiplied by 60% yields an unadjusted labor-related amount of $630.10. This amount multiplied by the annual wage index for this facility of 0.9659 yields an adjusted labor-related amount of $608.61. The non-labor related portion is 40% of the APC rate or $420.07. The sum of the labor and non-labor related amounts is $1,028.68 at 5 units, with multiple-procedure discount, is $3,086.04. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.299. This ratio multiplied by the billed charge of $6,153.85 yields a cost of $1,840.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,086.04 divided by the sum of all APC payments is 96.49%. The sum of all packaged costs is $1,105.99. The allocated portion of packaged costs is $1,067.17. This amount added to the service cost yields a total cost of $2,907.17. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $3,086.04. This amount multiplied by 200% yields a MAR of $6,172.08.
- Procedure code 1710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0696 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.12. This amount multiplied by the annual wage index for this facility of 0.9659 yields an adjusted labor-related amount of $0.12. The non-labor related portion is 40% of the APC rate or $0.08. The sum of the labor and non-labor related amounts is $0.20 multiplied by 4 units is $0.80. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total APC payment for this line is $0.80. This amount multiplied by 200% yields a MAR of $1.60.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 1710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $34.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $20.73. This amount multiplied by the annual wage index for this facility of 0.9659 yields an adjusted labor-related amount of $20.02. The non-labor related portion is 40% of the APC rate or $13.82. The sum of the labor and non-labor related amounts is $33.84. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $33.84. This amount multiplied by 200% yields a MAR of $67.68.

5. The total allowable reimbursement for the services in dispute is $6,423.88. This amount less the amount previously paid by the insurance carrier of $2,638.39 leaves an amount due to the requestor of $3,785.49. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,785.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,785.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	March 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.